FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041046

Facility Name: Provena Cor Mariae Center

Address: 3330 Maria Linden Drive (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7416 **Fax #** (815) 877-4299

IDPA ID Number: 371127787013

Date of Initial License for Current Owners: 06/01/95

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Michael R. Gordon

(Title) VP of Finance, CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 10/01/05

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	73	23,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	89	Sheltered Care (SC)	89	32,485	5
6		ICF/DD 16 or Less			6
7	152	TOTALS	162	56,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,906	12,206	6,170	22,282	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		30,102		30,102	12
13	DD 16 OR LESS					13
14	TOTALS	3,906	42,308	6,170	52,384	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.88%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/5/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/05/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 73 and days of care provided 6,170

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Provena Cor Mariae Center # 0041046 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	344,735	71,851	18,080	434,666		434,666		434,666			1
2	Food Purchase		298,500		298,500		298,500	3,105	301,605			2
3	Housekeeping	134,630	41,903		176,533		176,533		176,533			3
4	Laundry	56,288	16,096		72,384		72,384		72,384			4
5	Heat and Other Utilities			292,744	292,744		292,744	1,737	294,481			5
6	Maintenance	126,082	41,867	60,415	228,364		228,364	39,703	268,067			6
7	Other (specify):* **Pastoral Care/Dev.**	28,954	3,177	17,647	49,778		49,778	(5,984)	43,794			7
8	**TOTAL General Services**	690,689	473,394	388,886	1,552,969		1,552,969	38,561	1,591,530			8
	B. Health Care and Programs											
9	Medical Director			17,450	17,450		17,450		17,450			9
10	Nursing and Medical Records	1,755,353	145,031	246,830	2,147,214		2,147,214		2,147,214			10
10a	Therapy			379,247	379,247		379,247		379,247			10a
11	Activities	256,285	15,547	10,252	282,084		282,084	1,905	283,989			11
12	Social Services	82,652	1,386	1,967	86,005		86,005		86,005			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,094,290	161,964	655,746	2,912,000		2,912,000	1,905	2,913,905			16
	C. General Administration											
17	Administrative	277,139	40,441	745,200	1,062,780		1,062,780	(373,781)	688,999			17
18	Directors Fees											18
19	Professional Services			221,685	221,685		221,685	223,948	445,633			19
20	Dues, Fees, Subscriptions & Promotions			78,879	78,879		78,879	(47,028)	31,851			20
21	Clerical & General Office Expenses			132,741	132,741		132,741	(6,643)	126,098			21
22	Employee Benefits & Payroll Taxes			671,072	671,072		671,072	119,586	790,658			22
23	Inservice Training & Education			7,517	7,517		7,517	5,831	13,348			23
24	Travel and Seminar			11,778	11,778		11,778	6,512	18,290			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,088	96,088		96,088	6,996	103,084			26
27	Other (specify):* **Bad Debt**			47,405	47,405		47,405	(47,405)				27
28	**TOTAL General Administration**	277,139	40,441	2,012,365	2,329,945		2,329,945	(111,984)	2,217,961			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,062,118	675,799	3,056,997	6,794,914		6,794,914	(71,518)	6,723,396			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena Cor Mariae Center #0041046 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			325,696	325,696		325,696	94,756	420,452			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							187,161	187,161			32
33	Real Estate Taxes			1,020	1,020		1,020		1,020			33
34	Rent-Facility & Grounds							17,471	17,471			34
35	Rent-Equipment & Vehicles			2,879	2,879		2,879	925	3,804			35
36	Other (specify):*											36
37	**TOTAL Ownership**			329,595	329,595		329,595	300,313	629,908			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			391,518	391,518		391,518		391,518			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,587	34,587		34,587		34,587			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			426,105	426,105		426,105		426,105			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,062,118	675,799	3,812,697	7,550,614		7,550,614	228,795	7,779,409			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,457	30		9
10	Interest and Other Investment Income	(15,181)	32		10
11	Discounts, Allowances, Rebates & Refunds	(20,448)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,405)	27		24
25	Fund Raising, Advertising and Promotional	(57,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,012)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	347,814		34
35	Other- Attach Schedule	(6,007)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 341,807		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 228,795		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Provena Cor Mariae Center

ID# **0041046**

Report Period Beginning: **01/01/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development - Food	$ (23)	2	1
2	Development - Misc	(5,984)	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,007)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Provena Cor Mariae Center # 0041046 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(23)	3,128	0	0	0	0	0	0	0	0	0	3,105	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,737	0	0	0	0	0	0	0	0	0	1,737	5
6	Maintenance	0	610	39,093	0	0	0	0	0	0	0	0	39,703	6
7	Other (specify):*	(5,984)	0	0	0	0	0	0	0	0	0	0	(5,984)	7
8	**TOTAL General Services**	(6,007)	5,475	39,093	0	0	0	0	0	0	0	0	38,561	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,905	0	0	0	0	0	0	0	0	0	1,905	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1,905	0	0	0	0	0	0	0	0	0	1,905	16
	C. General Administration													
17	Administrative	0	(350,744)	(23,037)	0	0	0	0	0	0	0	0	(373,781)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	34,930	189,018	0	0	0	0	0	0	0	0	223,948	19
20	Fees, Subscriptions & Promotions	(57,435)	10,407	0	0	0	0	0	0	0	0	0	(47,028)	20
21	Clerical & General Office Expenses	(20,448)	13,805	0	0	0	0	0	0	0	0	0	(6,643)	21
22	Employee Benefits & Payroll Taxes	0	55,962	63,624	0	0	0	0	0	0	0	0	119,586	22
23	Inservice Training & Education	0	5,831	0	0	0	0	0	0	0	0	0	5,831	23
24	Travel and Seminar	0	6,512	0	0	0	0	0	0	0	0	0	6,512	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,996	0	0	0	0	0	0	0	0	0	6,996	26
27	Other (specify):*	(47,405)	0	0	0	0	0	0	0	0	0	0	(47,405)	27
28	**TOTAL General Administration**	(125,288)	(216,301)	229,605	0	0	0	0	0	0	0	0	(111,984)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(131,295)	(208,921)	268,698	0	0	0	0	0	0	0	0	(71,518)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Provena Cor Mariae Center** **#** **0041046** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	27,457	0	67,299	0	0	0	0	0	0	0	0	94,756	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,181)	0	202,342	0	0	0	0	0	0	0	0	187,161	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,471	0	0	0	0	0	0	0	0	17,471	34
35	Rent-Equipment & Vehicles	0	0	925	0	0	0	0	0	0	0	0	925	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,276	0	288,037	0	0	0	0	0	0	0	0	300,313	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(119,019)	(208,921)	556,735	0	0	0	0	0	0	0	0	228,795	45

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 3,128	$ 3,128	1
2	V	5	Utilities		Provena Senior Services	100.00%	1,737	1,737	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	610	610	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	1,905	1,905	4
5	V	17	Admin - Misc. Other	570,000	Provena Senior Services	100.00%	16,318	(553,682)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	202,938	202,938	6
7	V	19	Professional Services		Provena Senior Services	100.00%	34,930	34,930	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	10,407	10,407	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	13,805	13,805	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	55,962	55,962	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	5,831	5,831	11
12	V	24	Travel		Provena Senior Services	100.00%	6,512	6,512	12
13	V	26	Insurance		Provena Senior Services	100.00%	6,996	6,996	13
14	Total			$ 570,000			$ 361,079	$ * (208,921)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 3,318	$ 3,318	15
16	V	32	Interest		Provena Senior Services	100.00%	202,342	202,342	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	17,471	17,471	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	925	925	18
19	V	17	Admin Salaries	102,000	Provena Health Services	100.00%	67,071	(34,929)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	28,045	28,045	20
21	V	30	Depreciation		Provena Health Services	100.00%	63,981	63,981	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	189,018	189,018	22
23	V	17	Information Systems Salaries	73,200	Provena Health Services	100.00%	15,814	(57,386)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	6,612	6,612	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	7,054	7,054	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	41,860	41,860	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	17,503	17,503	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	27,418	27,418	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	11,464	11,464	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	32,039	32,039	30
31	V	39	Ancillary Services - Other	391,518	Provena Senior Services Pharmacy	100.00%	391,518		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 566,718			$ 1,123,453	$ * 556,735	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	5,261,654	20	$ 28,878	$	570,000	$ 3,128	1
2	5	Utilities	Management Fee Income	5,261,654	20	16,037		570,000	1,737	2
3	6	Maintenance - Other	Management Fee Income	5,261,654	20	5,629		570,000	610	3
4	11	Activities-Special Events	Management Fee Income	5,261,654	20	17,583		570,000	1,905	4
5	17	Admin - Misc. Other	Management Fee Income	5,261,654	20	150,633		570,000	16,318	5
6	17	Administrative Salaries	Management Fee Income	5,261,654	20	1,873,311	1,873,311	570,000	202,938	6
7	19	Professional Services	Management Fee Income	5,261,654	20	322,442		570,000	34,930	7
8	20	Dues,Subscriptions	Management Fee Income	5,261,654	20	96,069		570,000	10,407	8
9	21	Clerical Supplies	Management Fee Income	5,261,654	20	127,431		570,000	13,805	9
10	22	Employee Benefits	Management Fee Income	5,261,654	20	516,585		570,000	55,962	10
11	23	Education/Conference	Management Fee Income	5,261,654	20	53,828		570,000	5,831	11
12	24	Travel	Management Fee Income	5,261,654	20	60,116		570,000	6,512	12
13	26	Insurance	Management Fee Income	5,261,654	20	64,582		570,000	6,996	13
14	30	Depreciation	Management Fee Income	5,261,654	20	30,629		570,000	3,318	14
15	32	Interest	Management Fee Income	5,261,654	20	1,867,812		570,000	202,342	15
16	34	Rent - Facility	Management Fee Income	5,261,654	20	161,270		570,000	17,471	16
17	35	Rent - Equipment	Management Fee Income	5,261,654	20	8,543		570,000	925	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,401,378	$ 1,873,311		$ 585,135	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,146,264	10	$ 753,738	$ 753,738	102,000	$ 67,071	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		102,000	28,045	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		102,000	63,981	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		102,000	189,018	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	73,200	15,814	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		73,200	6,612	6
7	6	Information Systems - Equip Mair	Operating Expense	791,616	10	76,287		73,200	7,054	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	102,000	41,860	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		102,000	17,503	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	73,200	27,418	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		73,200	11,464	11
12	6	Information Systems - Equip Mair	Direct Cost	791,616	10	346,486		73,200	32,039	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,664,978	$ 1,691,687		$ 507,879	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 391,518	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 391,518	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										187,161	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 187,161	14
15	TOTALS (line 9+line14)						$	$			$ 187,161	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Provena Cor Mariae Center **#** 0041046 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 2,111	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 1,038	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,073)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 2,093	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 1,020	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001	942	9
2002		10
2003	974	11
2004	1,038	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Cor Mariae Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	153B004C 12-09-104-035	COMM SE COR LT IMPERIAL	$ 1,038.12	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,038.12	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1995	$ 670,894	1
2					2
3	TOTALS			$ 670,894	3

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	89		1995	1964	$ 1,035,000	$ 35,083	20	$ 35,083	$	$ 385,000	4
5	63			1997	2,508,246	62,711	40	62,711		517,171	5
6	10			2005	862,373	17,336	25	34,673	17,336	34,673	6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1995	131,756	6,588	20	6,588		66,683	9
10	VARIOUS			1996	154,526	9,772	14	9,772		92,831	10
11	VARIOUS			1997	515,025	24,768	14	24,768		261,478	11
12	VARIOUS			1998	175,915	5,239	11	5,239		58,034	12
13	VARIOUS			1999	10,976	45	6	45		10,819	13
14	VARIOUS			2000	47,412	4,741	6	4,741		42,120	14
15	VARIOUS			2001	50,678	5,086	9	5,086		22,886	15
16											16
17	DESC: METROFAX SHELVES & POSTS			2002			20			41	17
18	DESC: ARCHITECT SITE VISIT			2002	2,104	301	7	301		1,052	18
19	DESC: KITCHEN AREA WALLS			2002	2,475	495	5	495		1,733	19
20	DESC: AUTOMATIC OPERATOR ASSEMBLY FOR ENTR			2002	6,820	682	10	682		2,046	20
21	DESC: AUTOMATIC OPERATOR ASSEMBLY FOR ENTR			2002	1,680	168	10	168		504	21
22	DESC: 3RD FLOOR REMODLING			2002	59,484	3,966	15	3,966		12,844	22
23	DESC: FREEZER REPAIR-PARTS			2002	1,203	241	5	241		842	23
24	DESC: ROOFING			2002	27,000	2,700	10	2,700		9,450	24
25	DESC: ROOFING			2002	15,300	1,530	10	1,530		5,355	25
26	DESC: REPLACEMENT OF HEAT EXCHANGER			2002	1,953	391	5	391		1,367	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: INSTALLATION OF AWNING	2003	$ 1,710	$ 171	10	$ 171	$	$ 428	37
38	DESC: JOCKEY PUMP AND CONTROLLER	2003	3,340	167	20	167		418	38
39	DESC: REROOFING	2003	5,325	533	10	533		1,331	39
40	DESC: CARPET INSTALLATION	2003	1,937	387	5	387		968	40
41	DESC: FREEZER REPAIR	2003	1,726	345	5	345		863	41
42	DESC: REPAIR SHOWER FLOOR	2003	744	74	10	74		186	42
43	DESC: REPLACE BOILER SHEET METAL STACK	2003	2,560	128	20	128		320	43
44	DESC: COUNTER TOPS FOR THERAPY KITCHEN ARE	2003	1,103	110	10	110		276	44
45	DESC: COMPRESSOR FOR FREEZER	2003	584	58	10	58		146	45
46	DESC: REPAIR OUTSIDE LIGHTS	2003	2,369	158	15	158		316	46
47	DESC: ALARM SYSTEM	2003	11,753	1,175	10	1,175		2,938	47
48	DESC: CARPET INSTALLATION	2003	90,500	18,100	5	18,100		36,200	48
49	DESC: DOOR OPERATOR FOR MAIN ENTRANCE	2003	2,157	216	10	216		431	49
50	DESC: CODE ALERT SYSTEM	2003	4,700	470	10	470		1,175	50
51	DESC: ROOF REPLACEMENT	2003	38,000	3,800	10	3,800		7,600	51
52	DESC: TOSHIBA CTX670 TELEPHONE SYSTEM	2004	33,116	3,312	10	3,312		4,967	52
53	DESC: REPAIR WATERMAIN	2004	2,712	181	15	181		271	53
54	DESC: FRENCH DOORS	2004	4,000	267	15	267		400	54
55	DESC: WATER MAIN REPAIR	2004	6,819	455	15	455		682	55
56	DESC: EXTRACTION OF WATER - WATER DAMAGE	2004	1,040	208	5	208		312	56
57	DESC: PLAN BIDDING AND NEGOTIATION	2004	3,187	637	5	637		956	57
58	DESC: SAW AND PATCH	2004	2,494	499	5	499		748	58
59	DESC: SEAL & STRIPING OF PARKING LOTS	2004	7,008	1,402	5	1,402		2,102	59
60	DESC: DRAFTING OF DESIGN DRAWINGS - SNF AD	2004	610	122	5	122		183	60
61	DESC: CALL LIGHT ITMING SYSTEM FOR SKILLED	2004	4,208	421	10	421		631	61
62	DESC: UPGRADE KIT FOR SURFACE CODE ALERT U	2004	733	147	5	147		220	62
63	DESC: INSTALL BURN THROW DOOR	2004	818	82	10	82		82	63
64	DESC: REROOF MAINTENANCE SHOP	2004	21,947	2,195	10	2,195		2,195	64
65	DESC: MVP WATER SOFTENER	2004	1,658	166	10	166		166	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,868,782	$ 217,825		$ 235,162	$ 17,336	$ 1,594,440	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,868,782	$ 217,825		$ 235,162	$ 17,336	$ 1,594,440	1
2	DESC: RELOCATION OF UNDERGROUND CABLE FOR	2005	5,736	191	15	382	191	382	2
3	DESC: PARTS/LABOR TO REPLACE WATER DAMAGED	2005	5,730	287	10	573	287	573	3
4	DESC: TEKNOFLOR IN SKILLED NURSES STATION	2005	2,170	155	7	310	155	310	4
5	DESC: EXTERNAL SIGNAGE	2005	3,000	150	10	300	150	300	5
6	DESC: LANDSCAPING	2005	5,950	298	10	595	298	595	6
7	DESC: SIGNAGE	2005	1,914	96	10	191	96	191	7
8	DESC: TEKNOFLOR#73803 SHEET VINYL AND VINY	2005	8,780	439	10	878	439	878	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,902,062	$ 219,440		$ 238,391	$ 18,951	$ 1,597,670	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,170,809	$ 92,558	$ 92,558	$	9	$ 629,439	71
72	Current Year Purchases	187,738	9,447	18,894	9,447	9	18,894	72
73	Fully Depreciated Assets	140,581					140,581	73
74	Home office allocation		67,299	67,299				74
75	TOTALS	$ 1,499,128	$ 169,304	$ 178,751	$ 9,447		$ 788,915	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1991 CHEVY PICKUP	1995	$ 14,000	$	$	$	5	$ 14,000	76
77	Plant Engineering	2000 FORD ELDORADO	2000	42,500	4,250	4,250		10	23,375	77
78		NONCARE PORTION	2001	(15,062)		(941)	(941)		(10,824)	78
79										79
80	TOTALS			$ 41,438	$ 4,250	$ 3,309	$ (941)		$ 26,551	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,113,522	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 392,994	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 420,452	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 27,457	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,413,135	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home office allocation				18,396			5
6								6
7	TOTAL				$ 18,396 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 73,315 Description: Nursing - $69,186.16, Activities - $125.51, Plant Eng - $200, Admin - $2,878.80, Home Office - $925
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	n/a		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	2,876	$ 150,109	$	2,876	$ 150,109	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		929	48,470		929	48,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,461	180,668		3,461	180,668	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				391,518		391,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	7,266	$ 379,247	$ 391,518	7,266	$ 770,765	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Provena Cor Mariae Center **#** 0041046 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,947,364	$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,922,372	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	133,848		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 65,381,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,304,235	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,028,501	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	542,408		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,385,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	616,044		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,165,515	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,551,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,753,215	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,304,235	$	48

***(See instructions.)**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,625,309	1	
2	Restatements (describe):		2	
3	**FAS47 Change in accounting principal**	(271,871)	3	
4	**Adj. To Reconcile Consolidated Equity and Consolidated**	2,445,775	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,799,213	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(75,645)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock	(40,261)	9	
10	Stock Options Exercised		10	
11	Contributions and Grants	240,328	11	
12	Expenditures for Specific Purposes	(170,420)	12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (45,998)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,753,215	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,037,588	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,037,588	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	995,932	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 995,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(4,545)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,774	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 54,455	23
	D. Non-Operating Revenue		
24	Contributions	78,506	24
25	Interest and Other Investment Income***	15,181	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 93,687	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	173,364	28
28a	Misc. Income	119,943	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 293,307	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,474,969	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,552,969	31
32	Health Care	2,912,000	32
33	General Administration	2,329,945	33
	B. Capital Expense		
34	Ownership	329,595	34
	C. Ancillary Expense		
35	Special Cost Centers	391,518	35
36	Provider Participation Fee	34,587	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,550,614	40
41	**Income before Income Taxes (line 30 minus line 40)****	(75,645)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (75,645)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,900	2,080	$ 89,945	$ 43.24	1
2	Assistant Director of Nursing	908	936	21,326	22.78	2
3	Registered Nurses	4,453	4,773	112,109	23.49	3
4	Licensed Practical Nurses	24,915	26,424	575,231	21.77	4
5	CNAs & Orderlies	64,341	69,591	883,889	12.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,398	4,764	72,853	15.29	8
9	Activity Director	3,522	3,841	61,246	15.95	9
10	Activity Assistants	19,010	20,385	195,039	9.57	10
11	Social Service Workers	5,791	6,065	82,652	13.63	11
12	Dietician	1,884	2,080	44,392	21.34	12
13	Food Service Supervisor	1,496	1,512	12,078	7.99	13
14	Head Cook	7,554	8,245	98,858	11.99	14
15	Cook Helpers/Assistants	24,788	26,236	189,407	7.22	15
16	Dishwashers					16
17	Maintenance Workers	7,322	7,940	126,082	15.88	17
18	Housekeepers	15,409	16,319	134,630	8.25	18
19	Laundry	6,125	6,627	56,288	8.49	19
20	Administrator	1,912	2,080	98,264	47.24	20
21	Assistant Administrator					21
22	Other Administrative	5,417	5,745	103,044	17.94	22
23	Office Manager	420	480	7,987	16.64	23
24	Clerical	6,526	6,970	67,844	9.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral Care	1,944	2,080	28,954	13.92	33
34	TOTAL (lines 1 - 33)	210,035	225,173	$ 3,062,118 *	$ 13.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	210	$ 10,922	1,3	35
36	Medical Director	1455/mth	17,450	9,3	36
37	Medical Records Consultant	32	1,823	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	3,314	11,3	44
45	Social Service Consultant	19	1,110	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	308	$ 34,619		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	267	$ 13,584	10,3	50
51	Licensed Practical Nurses	3,619	117,493	10,3	51
52	Certified Nurse Assistants/Aides	818	14,073	10,3	52
53	TOTAL (lines 50 - 52)	4,704	$ 145,150		53

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Wester-Peters	Administrator	0	$ 98,264
Administrative Staff	Admissions	0	42,783
Administrative Staff	Human Resource	0	60,261
Administrative Staff	Admin Asst	0	28,326
Administrative Staff	Receptionist	0	39,518
Administrative Staff	Office Manager	0	7,987
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 277,139

B. Administrative - Other

Description	Amount
Corproate Service Fee	$ 102,000
Corporate Fee	73,200
Mgmt Fee	304,800
Mngt Fee Interest	265,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 745,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 208,342
Collection Expense	Various	2,311
Shredding	Various	1,218
Survey & Analytical Tools	Various	7,584
Living Design	Various	687
Outsourced Services	Various	1,543
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 221,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,200
Unemployment Compensation Insurance	26,107
FICA Taxes	220,218
Employee Health Insurance	264,687
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	12,121
Pension	86,201
Employee Recognition	5,037
Executive Benefits	5,663
Employment Screenings	7,838
Home Office Allocation	119,586
TOTAL (agree to Schedule V, line 22, col.8)	$ 790,658

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 113)	
Employee Recruitment	7,938
Dues & Subscription	9,920
Advertising & Public Relations	61,021
Home Office Allocation	10,407
Less: Public Relations Expense	( )
Non-allowable advertising	(57,435)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,851

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,778
Seminar Expense	
Home Office Allocation	6,512
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,290

**See instructions.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Provena Cor Mariae Center** **#** **0041046** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **6514 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **162**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,775** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **34,587**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **None**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.